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FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2012
NAME OF PROVIDER OR SUPPLIER BRISTOL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL, TN 37625			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the special focus survey completed on September 12, 2012, at Bristol Nursing Home, no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.		N 002		

Division of Health Care Facilities

Christopher A. Gadeky
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

9/24/12

STATE FORM

6699

ACG711

If continuation sheet 1 of 1